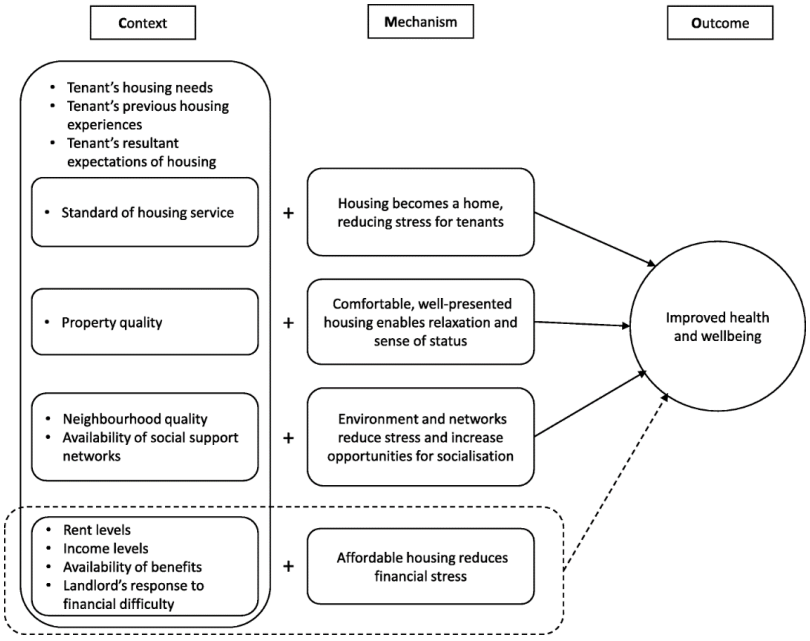
CATHOLIC COMMUNITY SERVICES
CATHOLIC HOUSING SERVICES
SERVING PEOPLE OF ALL BELIEFS

HOUSING & HOPE | A monthly email series on housing & homelessness.

Lifelong Partners: CCS/CHS and the Provision of Specialized Care

As part of our philosophy to uphold the sanctity and dignity of all human life, Catholic Community Services and Catholic Housing Services (CCS/CHS) strive to provide compassionate service and provision of care for each person, at every stage and condition of life. We believe that every child should grow up in a safe, loving and nurturing environment, that elders should live in security and dignity, and that every person has the right to a safe, affordable place to call home. Our services are thus tailored to meet the varied needs of the diverse populations we serve – from veterans, to children and families, to elders requiring assistance with transportation, shopping, and medical care.

We also recognize the inextricable link between housing and health, and place a strong emphasis on supporting the specific needs of each person in our care in order to provide holistic services that promote stability, security, and dignity across the life course. Doing so requires programs that can be adapted to meet the needs of these various populations in Western Washington. One such population is our geriatric clients struggling with accessing housing and health care.

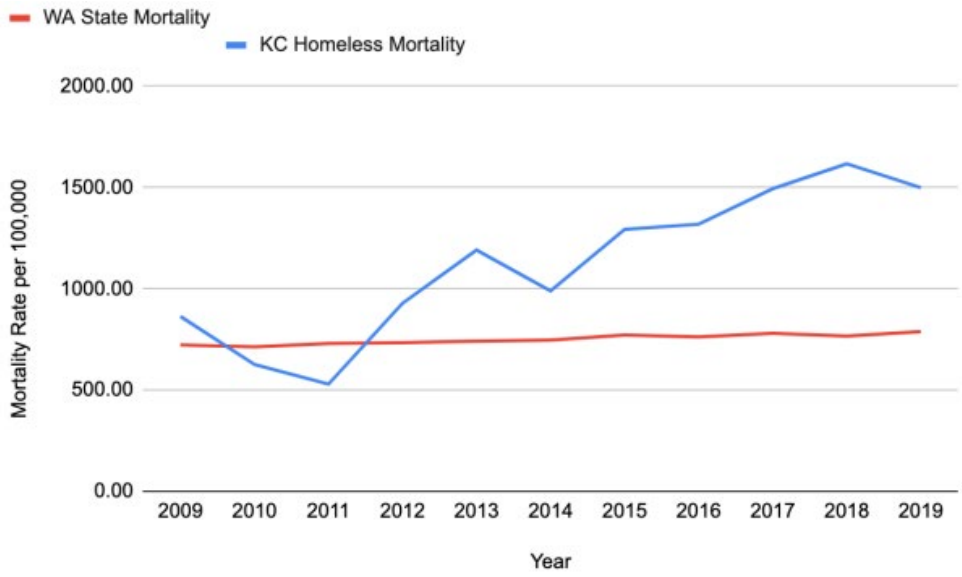


Source: "Housing as a social determinant of health and wellbeing: Developing an empirically-informed realist theoretical framework,"

(Rolfe et al., 2020)

Housing as Healthcare

Data consistently suggests that unhoused people have poorer health statuses and outcomes than the housed population, requiring "complex care management because of associated medical troubles (somatic and psychiatric) and social difficulties." Further, experiencing homelessness "exacerbates health problems and the [in]ability to access appropriate care," according to U.S Housing and Urban Development (HUD). Housing insecurity and instability increases stress and inhibits one's ability to satisfy personal needs (such as eating and sleeping well, caring for injuries, and taking medication), and HUD reports that the mortality rate for chronically homeless individuals is four to nine times higher than for the general population.



Comparison of King County Homeless and Washington State Crude Mortality Rates, 2009-2019.

Source: "Without shelter, people die: disproportionate mortality rates among King County's homeless population, 2009 – 2019," (Scott, 2020).

Despite the evidenced need for increased healthcare programs and systems to target this inequity, there remains significant barriers to healthcare for the unhoused, including a lack of health insurance, access to transportation to appointments, negative past experiences or fears of discrimination, and the need to prioritize other necessities. Studies indicate that nearly three quarters of unhoused people report unmet health needs, and this disparity is particularly pronounced for elders and those with chronic illnesses. An article published by Cambridge University Press in 2016 notes that "homelessness among diverse groups of older people is a significant form of social marginalization," and "should be a pressing concern" for anyone interested in housing equity.

The National Alliance to End Homelessness writes, "When housing is a platform, people…who are experiencing homelessness have the opportunity to engage in treatment fully without the additional stress of living on the streets." Therefore, housing and shelter programs which incorporate supportive services are a "cost-effective solution to homelessness for those with the most severe health, mental health and substance abuse

challenges." Integrating specialized health measures, such as medication reminders, assistance with appointment scheduling and transportation to and from appointments, and consistent guidance and support is crucial to support the mental and physical health of vulnerable and unhoused populations, and particularly for those with chronic disorders.

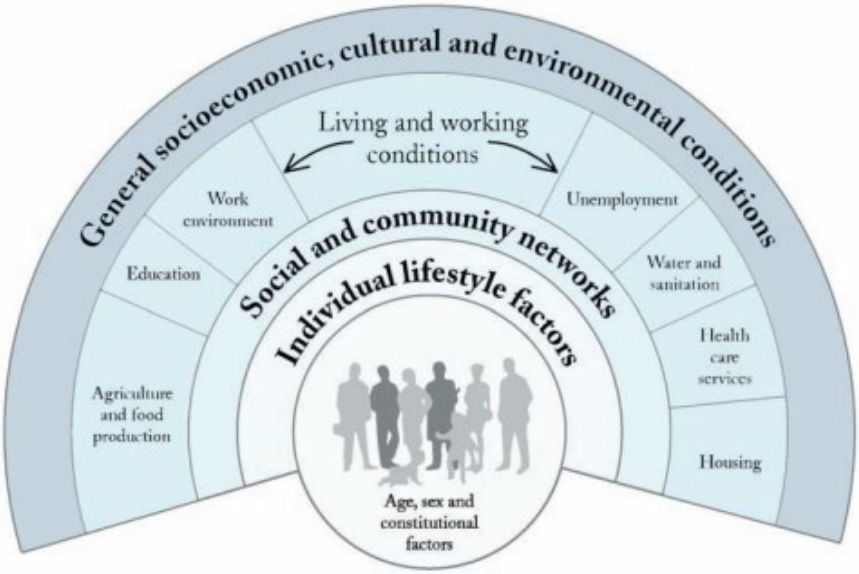


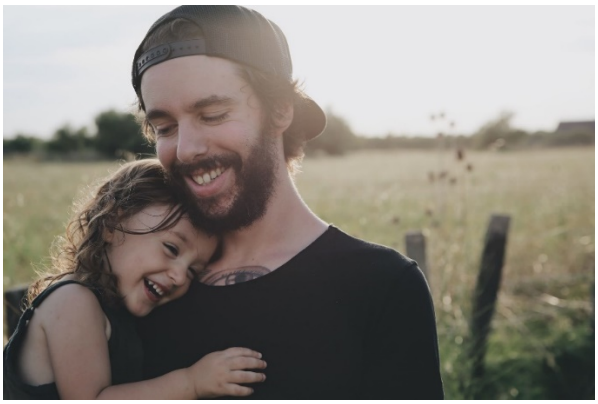
Figure shows one influential model of the determinants of health that illustrates how various health-influencing factors are embedded within broader aspects of society.

Source: "Social Determinants of Health," (Mikkonen & Raphael, 2010)

Through our specialized programs targeting specific populations, and through supportive case management services at our shelters and housing facilities, CCS/CHS honors the diverse experiences and needs of each person who in our care. Above all, we aim to uphold the dignity of all those who choose to share their stories and their struggles with us, and we strive to provide individualized care, support, and love to all those we serve.

Benedict House

Benedict House, opened in 2006, remains the only facility for unhoused men in Kitsap County. Benedict House provides emergency and transitional housing for 24 men experiencing homeless, as well as three additional respite beds for those needing time to recover after medical treatment. Benedict House offers case management services with an emphasis on addiction recovery and family reunification. Case managers assist with resume-building and job applications, setting up medical and dental appointments and substance abuse treatment, as well as with applying for benefit programs and housing assistance (including securing necessary documentation like social security information). The men are provided with fresh sheets, towels, and toiletries, as well as clothing for job interviews. The building also includes a family room to support the reunification of fathers and their children. Christy notes that "Each man's story and situation is different from the other and we base our care on their circumstances." To help ensure continuity of care, hospitals utilize the respite bed by contacting the shelter and coordinating entry for men who need additional assistance with medication, meals, and transportation to medical appointments.



Father and child

In non-COVID times, Benedict House is an evening shelter – residents leave in the morning after breakfast and return in the evening for dinner. Men usually stay for 90 days but are sometimes granted month-by-month extensions if they are showing great progress towards their goals and could genuinely benefit from additional support. Some men first require medical, dental and mental health care before they are able to make meaningful progress towards other goals. In an attempt to keep the men safe and healthy during the pandemic, Benedict House has been operating 24-hours a day and providing breakfast, lunch, and dinner. New COVID guidelines allow the men to stay at the shelter until they find housing.

What makes Benedict House truly special is the sense of community it provides. Cindy McNabb, Development Manager for CCS in the Southwest region, says that every time she has been to Benedict House, the experience has been amazing. “There is such a sense of community, home and hope - a warmth that you don't always find in a shelter,” she said. “There is a peaceful atmosphere, like walking into a beloved relative's house.” Residents consistently describe Benedict House as a blessing that allows them to work seriously towards permanent housing.

This month’s Housing & Hope story was written by Christy Raschke, program supervisor at Benedict House. It chronicles her relationship with a respite resident, Jonah*, and how, as their relationship develops, they grapple with his diagnosis of liver cancer diagnoses together. Please be advised before reading that this story involves chronic illness and death. We chose to share this story, both in honor of Jonah’s life, and to represent the continuum of care we provide to our clients across the life course.

The Man Who Lived Behind Walmart

Jonah lived in a tent in the woods behind a local Walmart for years. He lived with his wife, but the relationship was marred by stress, addiction, and the uncertainties of day-to-day life that result from financial instability. When Jonah became so ill that he couldn’t get out of his tent, the paramedics hiked in and carried him out through the mud and muck. Jonah came from the hospital to our shelter as a respite resident in the fall of 2019. He was grumpy, grouchy and snippy with everyone. He was also scared. He was learning that he had liver cancer, but he refused to complete the testing which would provide the final diagnosis. Jonah felt if he didn’t know, then it wasn’t really true.

Our staff reached out to Jonah, offering compassion, stability and assistance with medical care. Jonah slowly began reaching out to other residents. He would buy a couple of pies to share with the men for dessert, or surprise everyone with popsicles during the summer. After a few months Jonah left our shelter. He returned to the tent to live with his wife. I would run into Jonah every once in a while, at Walmart, where he was buying a new tarp or replacing a propane tank. He would always smile and talk, and talk, and talk! He would tell me about other residents he had seen from the shelter, and about the staff he had gotten to know well. Then he would be off - returning to the struggles of living in a tent, in the woods, behind Walmart.

Benedict House

In December 2020, just before Christmas, Jonah came back to us from the hospital, again as a respite resident. He was very weak and very sick. Further tests were revealing the severity of Jonah's illness. As his case manager, I spent many hours talking with Jonah. He would sometimes share his fears and concerns about the prognosis, but more often, Jonah proudly shared that he was giving his bike to a Benedict House resident, or his coat to another guy he met on the street. He was beginning the process of accepting death. We watched Jonah growing steadily weaker. He would return from a medical appointment in denial and confusion, often not understanding what had been said to him at the appointment. I would help review the paperwork and explain his doctor's suggested treatments.

One morning in January, Jonah and I were reviewing the paperwork from that day's appointment. His doctor used words like "terminal," "comfort measures," "settling personal affairs," and other terms that revealed to Jonah what his future held. I called the doctor – a phenomenal gastroenterologist who provided compassion and care to Jonah (even as an elderly man who lived in a tent and sometimes used drugs to numb the pain), always treating him with kindness, sensitivity, and respect. I sat down with Jonah after speaking with his doctor. Very quietly, Jonah asked me if he was going to die. I had to answer yes. After explaining that the doctor prescribed morphine to help ensure Jonah was in minimal discomfort, I asked Jonah why he wasn't taking the morphine despite obviously being in a great deal of pain.

He explained that he has spent his whole life trying to kick his drug habit, and it was difficult to understand that now people *want* him to take drugs. This was a deep-rooted internal conflict that he was struggling to come to terms with. We talked for some time about what it meant to be in hospice. Jonah was still asking for full resuscitation and for all measures to be taken that would keep him alive. He was still unready to accept that he was going to die. He didn't want to give up. We spent hours discussing the different levels of care and how to best keep him comfortable, also working with his wife to create the best plan. Eventually Jonah began to accept a morphine tablet every twelve hours, but it barely helped the pain. Soon, he began to ask about God, about the process of death, and about the decisions he was being asked to make. I felt so privileged to help this man walk through these steps each day leading up to his death. Though he frequently shed tears, he liked to remind me that he had allergies. We would smile. Oh, how hard it must have been to try to be so tough and strong.

Christy Raschke, Benedict House Program Supervisor

Jonah saw his oncologist in the last week of January, making a follow-up appointment for April despite the oncologist's assurance that he would no longer be alive by then. A couple of days later Jonah asked me if I thought the oncologist was correct. I reminded Jonah that he was unable to eat, spent most of his days sleeping, and was barely strong enough to come downstairs. Jonah understood that this was part of the process; his body was wearing out and preparing him for the next step of his life. Jonah knew that my faith in the Lord is the driving factor in my life. He knew that my husband died eleven years ago after a long illness and would ask about that process. These conversations of trust and honesty were a privilege for me. Jonah had begun reading a Bible given to him at Christmas. He told me once, "I am going to a better place, and that is pretty amazing considering I have not been a very nice person most of my life." Jonah found love for Jesus and came to believe that he was going to heaven. He stated with confidence that he was not afraid to die.

On February 2nd Jonah was very weak. He had not eaten in days and his pain became unmanageable. It was time to return to the hospital, but Jonah did not want to go. However, Jonah trusted us due to the countless hours another case manager and I had spent with him.

Jonah went to the hospital. The Benedict House residents cried, patting him on the shoulder and rubbing his head as they said their goodbyes. Most of the men realized that this would

be their final farewell to Jonah. I talked to him several times while he was in the hospital, and the residents sent him cards, all deeply appreciated by Jonah. We felt privileged to help this man through the process leading up to death, to show him love and compassion, and to give him hope. Jonah died of liver cancer fifteen days after arriving at the hospital. He died with his wife by his side. He died knowing how much we, at Benedict House, cared about him.

I consider it a privilege and a blessing to have worked with Jonah when he was grumpy, grouchy, scared. I believe it was a privilege to dialogue with him. And I am thankful that, when the time was right, Jonah was able to live out his last couple of weeks at the hospital to make the process of dying as comfortable and peaceful as possible.

Working at Benedict House, I am given daily opportunities to show compassion, love and genuine acts of service and care for our residents. Some act grouchy, grumpy, and mean and all are scared of the lives they are living. We have the opportunity to bless them and be blessed by them, to serve them with love and compassion. It requires looking beyond the surface of the unhoused person we are working with. It requires looking at the heart and seeing what Jesus sees in all of us, his children.

* Name has been changed to protect client confidentiality.

Story by Christy L. Raschke, Benedict House Program Supervisor

Thank you to all who have completed our Housing & Hope six-month survey! We appreciate your feedback and assistance in guiding the remaining stories to be as interesting and informative as possible. The survey is still available, so please consider taking a few minutes to let us know what you want to see next month!

If you would like to learn more about a particular issue as it relates to the impact of race on experiencing homelessness, please contact Sienna at SiennaH@ccsww.org. If you received this email from an outside source, please sign up if you would like to receive our monthly Housing & Hope emails directly. For an archive of each month's story, please visit the series homepage.